

- I. The prospectively determined individual home health agency's rate will be adjusted under certain circumstances which are:
1. Administrative errors on the part of the DOM or the agencies that result in erroneous payments. Overpayments or underpayments resulting from errors will be corrected when discovered. Overpayments will be recouped by the DOM and underpayments will be paid to the home health agency. In no case will payment adjustments be made for administrative error or audit findings prior to notifying the appropriate agency and affording an opportunity to present facts and evidence to dispute the exception.
  2. The amendment of a previously submitted cost report. Such amendments must be submitted within eighteen (18) months following the close of the cost report period that is being amended. If an increase or decrease in the rate is computed as a result of the amended cost report, claims history will be adjusted retroactive to the effective date of the original rate.
  3. The information contained in the cost report is found to be intentionally misrepresented. Such adjustment shall be made retroactive to the date of the original rate. At the discretion of the DOM, this shall be grounds to suspend the home health agency from the Mississippi Medicaid Program until such time as an administrative hearing is held, if requested by the home health agency.
  4. The home health agency experiences extraordinary circumstances which may include, but are not limited to riot, strike, civil insurrection, earthquakes or flood.
  5. The home health agency experiences a change of ownership (See Section V.1.)

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6. Under no circumstances shall such adjustment exceed the class ceiling established for the respective classes.
7. The receipt of the final or amended final cost report from the Medicare intermediary.
8. Resolution by the Medicare intermediary of a provider appealed adjustment on a previous year final cost report that was applied to an original desk review. The rates for all years affected by the appealed adjustment for which the final cost report has not been received will be recalculated and claims history adjusted retroactive to the effective date of the original rate.

J. Costs incurred for the acquisition of durable medical equipment and supplies are non-allowable costs since they are reimbursed outside of the home health agency visit rate.

#### IV. Rate Methodology

A. Prospective Rates. The DOM will utilize a prospective rate of reimbursement and will not make retroactive adjustments except as specified in these regulations. The prospective rates will be determined from cost reports and will be set on a yearly (October 1 - September 30) basis from the date established and will be applicable to all facilities with a valid provider agreement. An exception to this is that rates will be set for fifteen (15) months for the period July 1, 1996 through September 30, 1997. This will allow for a transition to the new rate year due to the change in the due dates of cost reports. Total payments per month for each home health patient may not exceed the average Medicaid nursing facility rate per month as determined based on the nursing facility rates computed at July 1 of each year.

Providers will be paid the lower of their prospective rate as computed in accordance with this plan or their usual and customary charge.

In order to compensate for new or expanded services not accounted for in the reporting year, the home health agency must identify such services no later than each June 30, prior to the start of the October 1 rate determination, and submit financial data in order for a determination to be made of the impact on the cost report.

B. Payment for Home Health Services. Home health services include skilled nursing services, physical therapy services, speech therapy services, home health aide services and medical supplies. Payments of medical supplies which are directly identifiable supplies furnished to individual patients and for which a separate charge is made will be reimbursed as described in Section IV. D. 5., of this plan. Payments of durable medical equipment and supplies are reimbursed as described in Section VIII, of this plan.

Prospective rates and ceilings will be established for the home health visits. Services must be provided at the recipient's place of residence on his physician's orders as part of a written plan of care that the physician reviews every sixty (60) days. A recipient's place of residence, for home health services, does not include a hospital, skilled nursing facility, nursing facility, or intermediate care facility except for home health services in an intermediate care facility that are not required to be provided by the facility under federal regulations.

Home health visits reimbursed by this plan include:

1. Skilled Nursing Visit - Nursing services provided by or under the supervision of registered nurses currently licensed in the State of Mississippi. These services must be provided directly by agency staff in accordance with Mississippi State Department of Health, Division of Health Facilities Licensure and Certification standards and in accordance with orders of the patient's physician and under a plan of treatment established by such physician.

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2. Physical Therapy Visit - These services shall be given in accordance with the responsible physician's written order by a physical therapist or physical therapy assistant currently licensed in the State of Mississippi to practice as a physical therapist or physical therapist assistant. The physician's order shall be specific as to modalities to be utilized and frequency of therapy. Each visit should be for a period of not less than thirty (30) minutes.

These services must be provided by agency staff directly or provided under arrangement through a contractual purchase of services in accordance with Mississippi State Department of Health, Division of Health Facilities Licensure and Certification standards and in accordance with orders of the patient's physician and under a plan of treatment established by such physician.

3. Speech Therapy Visit - The speech pathologist shall be currently licensed by the Mississippi State Department of Health at the time the services are provided. The audiologist shall be currently licensed by the Mississippi State Department of Health. Speech pathology and audiology services shall be given in accordance with the responsible physician's written order by a licensed speech pathologist or a licensed audiologist. The frequency of service shall be specified in the physician's order. Each visit should be for a period of not less than thirty (30) minutes.

These services must be provided by agency staff directly or provided under arrangement through a contractual purchase of services in accordance with Mississippi State Department of Health, Division of Health Facilities Licensure and Certification standards and in accordance with orders of the patient's physician and under a plan of treatment established by such physician.

4. Home Health Aide Visit - These services shall be given under a physician's order and shall be supervised by a Registered Nurse. When appropriate, supervision may be given by a physical therapist, a speech therapist, or an occupational therapist. These services must be provided by agency staff directly or provided under arrangement through a contractual purchase of services in accordance with Mississippi State Department of Health, Division of Health Facilities Licensure and Certification standards and in accordance with orders of the patient's physician and under a plan of treatment established by such physician.

C. Trend Factor

A trend factor will be computed in order to adjust costs for anticipated increases or decreases due to changes in the economy. This will be done by using the Global Insight Health Care Cost Review - National Forecasts CMS Home Health Agency Market Basket, or its successor. The moving averages from the fourth quarter of the previous calendar year, prior to the start of the rate period, used are Wages and Salaries, Employee Benefits, Fixed Capital, Medical Equipment, Utilities, Telephone, Paper Products, Postage, Administrative Costs, Transportation, Insurance, and Miscellaneous. Relative weights are obtained from the same period National Market Basket Price Proxies - Home Health Agency Operating Costs.

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An example of the computation of the trend factor is described below.

COLUMN 1	COLUMN 2	COLUMN 3	COLUMN 4	COLUMN 5
EXPENSE CATEGORY	RELATIVE WEIGHT	ADJUSTED RELATIVE WEIGHT COL 2/COL 1 TOTAL LINE	PERCENT GROWTH QUARTER 96:4	TREND FACTOR COL 3 * COL 4
Wages & Salaries	64.23%	0.6423	0.029	0.0186
Employee Benefits	13.44%	0.1344	0.018	0.0024
Fixed Capital	1.76%	0.0176	0.032	0.0006
Transportation	3.41%	0.0341	0.027	0.0009
Utilities	0.83%	0.0083	0.031	0.0003
Telephone	0.73%	0.0073	0.014	0.0001
Paper Products	0.53%	0.0053	0.053	0.0003
Postage	0.72%	0.0072	0.000	0.0000
Administrative Costs	7.59%	0.0759	0.033	0.0025
Medical Equipment	0.88%	0.0088	0.000	0.0000
Insurance	0.56%	0.0056	0.022	0.0001
Miscellaneous	5.32%	0.0532	0.028	0.0015
Total	100.00%	1.0000		0.0273

The trend factor of 2.73%, as determined above for a one year period, will be adjusted based on the cost report period in order to trend costs from the mid-point of the cost report period to the mid-point of the rate period.

D. Setting of Type of Visit Ceilings and Rates

1. Skilled Nursing Visit rates are determined in accordance with the following rate methodology. Home Health Agencies are reimbursed for skilled nursing visits at the lower of the following:
  - (a) trended cost, plus a profit incentive, but not greater than 105% of the median, which is computed as follows:

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- (1) determine the cost per visit as computed on the desk review of each home health agency cost report for the period ended in the calendar year prior to the start of the standard rate year of October 1 through September 30;
  - (2) trend the costs, using the trend factor determined in paragraph C, above, to account for the time difference between the midpoint of the cost report period and the midpoint of the rate period;
  - (3) array the trended costs from the lowest to the highest with the total number of skilled nursing visits and determine the cost associated with the median visit (interpolate, if necessary);
  - (4) multiply the median visit trended cost by 105% to determine the ceiling;
  - (5) for agencies with trended cost below the 105% of the median amount, compute 50% of the difference between the ceiling and the higher of their trended cost or the median trended cost to determine the profit incentive;
  - (6) sum the lesser of each home health agency's trended cost or the 105% of the median ceiling and the profit incentive determined in (5), above; or,
- (b) the sum of the following:
- (1) the ceiling for direct care and care related costs for nursing facilities at a case mix score of 1.000 as determined each July 1 prior to the start of the October 1 through September 30 home health agency rate period; and
  - (2) the ceiling for administrative and operating costs for Large Nursing Facilities as determined each July 1 prior to the start of the October 1 through September 30 home health agency rate period.
- (c) plus the medical supply add-on as computed in Section IV. D. 5.
2. Physical Therapy Visits are reimbursed on a fee-for-service basis at an all inclusive, per visit rate of \$65.00 plus the medical supply add-on as computed in Section IV. D. 5.
  3. Speech Therapy Visits are reimbursed on a fee-for-service basis at an all inclusive, per visit rate of \$65.00 plus the medical supply add-on as computed in Section IV. D. 5.
  4. Home Health Agencies are reimbursed for home health aide visits based on the following methodology:
    - (a) trended cost, plus a profit incentive, but not greater than 105% of the median, plus the medical supply add-on, which is computed as follows:

- (1) determine the cost per visit as computed on the desk review of each home health agency cost report for the period ended in the calendar year prior to the start of the standard rate year of October 1 through September 30;
- (2) trend the costs, using the trend factor determined in paragraph C, above, to account for the time difference between the midpoint of the cost report period and the midpoint of the rate period;
- (3) array the trended costs from the lowest to the highest with the total number of home health aide visits and determine the cost associated with the median visit (interpolate, if necessary);
- (4) multiply the median visit trended cost by 105% to determine the ceiling;
- (5) for agencies with trended cost below the 105% of the median amount, compute 50% of the difference between the ceiling and the higher of their trended cost or the median trended cost to determine the profit incentive;
- (6) sum the lesser of each home health agency's trended cost or the 105% of the median ceiling and the profit incentive determined in (5), above, plus the medical supply add-on as computed in Section IV. D. 5.

5. The Medical Supply payment amount that will be added on to each discipline will be reimbursed at the lower of the following:

- (a) trended medical supply cost per visit computed as follows:
  - (1) determine the medical supply cost per visit as computed on the desk review of each home health agency cost report for the period ended in the calendar year prior to the start of the standard rate year of October 1 through September 30 (divide total medical supply cost per the desk review by total medical supply charges; multiply this ratio times Medicaid medical supply charges per the desk review; divide this number by total Medicaid visits);
  - (2) trend the costs, using the trend factor determined in paragraph C, above, to account for the time difference between the midpoint of the cost report period and the midpoint of the rate period; or
- (b) 105% of the median medical supply trended cost, which is computed as follows:
  - (1) determine the medical supply cost per visit as computed on the desk review of each home health agency cost report for the period ended in the calendar year prior to the start of the standard rate year of October 1 through September 30 (divide total medical supply cost per the desk review by total medical supply charges; multiply this ratio times Medicaid medical supply charges per the desk review; divide this number by total Medicaid visits);
  - (2) trend the costs, using the trend factor determined in paragraph C, above, to account for the time difference between the midpoint of the cost report period and the midpoint of the rate period;
  - (3) array the trended costs from the lowest to the highest with the total number of Medicaid visits per the desk review and determine the cost associated with the median visit (interpolate, if necessary);
  - (4) multiply the median visit trended cost by 105% to determine the ceiling.

#### V. New Providers

##### 1. Changes of Ownership

For purposes of this plan, a change of ownership of a home health agency includes, but is not limited to, inter vivos gifts, purchases, transfers, lease arrangements, cash and/or stock transactions or other comparable arrangements whenever the person or entity acquires a majority interest of the facility. The change of ownership must be an arm's length transaction consummated in the open market between non-related parties in a normal buyer - seller relationship.

Prior to the DOM's concurrence of a change of ownership transaction, the following information is required in order for the DOM to determine the appropriate allowance for depreciation and interest on capital indebtedness:

- a. the prior owner's basis in the assets sold;
- b. the purchase amount of these assets by the new owner;
- c. the amount of annual depreciation and interest expense for the buyer; and
- d. a description of the assets being purchased.

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A home health agency which undergoes a change of ownership must notify the DOM in writing of the effective date of the sale. The seller's provider number will be closed and a new provider number assigned to the new owner after the new owner submits the provider enrollment information required under DOM policy. The new owner is not allowed to use the provider number of the old owner to file claims for reimbursement.

The new owner will be reimbursed at the previous owner's rate until the rate is adjusted based on the new owner's initial cost report. This adjusted rate will be effective retroactive to the date of the change of ownership. A prospective rate will also be determined based on this initial cost report.

The new owner, upon consummation of the transaction effecting the change of ownership, shall as a condition of participation, assume liability, jointly and severally, with the prior owner for any and all amounts that may be due or become due to the Medicaid Program, and such amounts may be withheld from the payment of claims submitted when determined. However, the new owner shall not be construed as relieving the prior owner of his liability to the Division.

2. New Home Health Agencies

When new providers are established that are not changes of ownership, the provider shall be reimbursed at the maximum rate for each type of home health visit pending the receipt of the initial cost report. After receipt of the initial cost report, a rate will be determined that is retroactive to the date of the establishment of the provider.

Notwithstanding any other provision of this section, the Division of Medicaid, as required by state law, shall reduce the rate of reimbursement to providers for any service by five percent (5%) of the allowed amount for that service. The Federal match will be paid based on the reduced amount.

VI. Provider Participation

Payments made in accordance with the standards and methods described in this attachment are designed to enlist participation of a sufficient number of home health agencies in the program, so that eligible persons can receive the medical care and services included in the State Plan at least to the extent these services are available to the general public. Providers must be certified to participate as a home health agency under Title XVIII (Medicare) of the Social Security Act, and meet all applicable state laws and requirements.

VII. Payment in Full

Participation in the program shall be limited to home health agencies who accept, as payment in full, the amount paid in accordance with the State Plan.

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**VIII. Durable Medical Equipment**

- A. The payment for purchase of Durable Medical Equipment (DME) is made from a statewide uniform fee schedule not to exceed 80 percent of the rate established annually under Medicare (Title XVIII of the Social Security Act), as amended.
- B. The payment for rental of DME is made from a statewide uniform fee schedule based on 10 percent of the above purchase allowance not to exceed ten (10) months. After rental benefits are paid for ten (10) months, the DME becomes the property of the Mississippi Medicaid recipient unless otherwise authorized by the Division of Medicaid through specific coverage criteria.
- C. The payment for purchase of used DME is made from a statewide uniform fee schedule based not to exceed 50 percent of the above purchase allowance.
- D. The payment for repair of DME is the cost, not to exceed 50 percent of the above purchase allowance.
- E. The payment for other individual consideration items must receive prior approval of the Division and shall be limited to the amount authorized in that approval.

All terms of the Division's Durable Medical Equipment Reimbursement and Coverage Criteria are applicable.

Durable Medical Equipment (DME) for EPSDT recipients, if medically necessary, which exceed the limitations and scope for Medicaid recipients, as covered in this Plan, are reimbursed according to the methodology in the above paragraphs.

Notwithstanding any other provision of this section, the Division of Medicaid, as required by state law, shall reduce the rate of reimbursement to providers for any service by five percent (5%) of the allowed amount for that service. The Federal match will be paid based on the reduced amount.

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**Medical Supplies**

- A. The payment for purchase of Medical Supplies is made from a statewide uniform fee schedule not to exceed 80 percent of the rate established annually under Medicare (Title XVIII of the Social Security Act), as amended.
- B. The payment for other individual consideration items must receive prior approval of the Division and shall be limited to the amount authorized in that approval.

All terms of the Division's Medical Supplies Reimbursement and Coverage Criteria are applicable.

Medical Supplies for EPSDT recipients, if medically necessary, which exceed the limitations and scope for Medicaid recipients, as covered in this Plan, are reimbursed according to the methodology in the above paragraphs.

Notwithstanding any other provision of this section, the Division of Medicaid, as required by state law, shall reduce the rate of reimbursement to providers for any service by five percent (5%) of the allowed amount for that service. The Federal match will be paid based on the reduced amount.

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